

# Implementation of Hawaii's Prepaid Health Care Act: Root Cause of a Health Care Monopoly

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## I. Introduction

Hawaii's Prepaid Health Care Act ("PPHCA")<sup>1</sup> of 1974 was lauded as the "first employer-mandated health care legislation in the country."<sup>2</sup> Created to improve health care access for the uninsured, it provides that all employees in Hawaii who work twenty hours or more per week have access to health care. Some three decades later, this Hawaii experiment has produced unexpected results. The overall insurance coverage rate is estimated to be the same today as it was prior to the enactment of the PPHCA.<sup>3</sup> More importantly, the implementation of the PPHCA has instead become the root cause of a health care monopoly in Hawaii. The manner in which the Act has been administered via the Prepaid Health Care Advisory Council ("Council") raises questions concerning antitrust behavior. This article discusses the underlying reasons for these concerns. The scope of this article, however, does not attempt to develop a detailed antitrust analysis. A brief overview here may be helpful to understanding the organization of this article.

In 1974, Hawaii enacted what was truly an innovative plan – the PPHCA – not knowing that Congress

would, within months, preempt the PPHCA by passing the federal Employees Retirement Income Security Act ("ERISA").<sup>4</sup> ERISA was designed to assure Americans that their pension and other retirement benefits would be solvent and well managed. As such, ERISA's effectiveness depended on universal applicability which it achieved with a broad preemption clause. Unfortunately, with this preemption clause, ERISA immediately precluded Hawaii's brand-new PPHCA as well as other states' initiatives.<sup>5</sup> Congress later amended ERISA, giving Hawaii a unique exemption. This exemption from ERISA preemption was granted partly because the PPHCA was a new concept in health care delivery, essentially a state-wide experiment in comprehensive employer mandated benefits.<sup>6</sup> Congress "allowed Hawaii to experiment with [what was then] innovative health care legislation."<sup>7</sup> However, the language of the exemption amendment and the manner in which the Act has been implemented have led to the development of a health care monopoly in Hawaii.

## References

1. Haw. Rev. Stat. §393-7 (1993). The Prepaid Health Care Act states that:  
(a) A prepaid health care plan shall qualify as a plan providing the mandatory health care benefits required under this chapter if it provides for health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type, as specified in 393-12 (a) (1) or (2), which have the largest numbers of subscribers in the State. This applies to the types and quantity of benefits as well as to limitations on reimbursability, including deductibles, and to required amounts of co-insurance.  
The director, after advice by the prepaid health care advisory council, shall determine whether benefits provided in a plan, other than the plan of the respective type having the largest numbers of subscribers in the State, comply with the standards specified in this subsection.  
(b) A prepaid group health care plan shall also qualify for the mandatory health care benefits required under this chapter if it is demonstrated by the health care plan contractor offering such coverage to the satisfaction of the director after advice by the prepaid health care advisory council that the plan provides for sound basic hospital, surgical, medical, and other health care benefits at a premium commensurate with the benefits included taking proper account of the limitations, co-insurance features, and deductibles specified in such plan....  
*Id.*
2. Angelo A. Stio, *State Government: The Laboratory for National Health Care Reform*, 19 SETON HALL LEGIS. J. 322, 340 (1994).
3. Norman K. Thurston, *Labor Market Effects of Hawaii's Mandatory Employer-Provided Health Insurance*, 51 INDUS. & LAB. REL. REV. 117, 118 (1997). "Using enrollment data, Dick (1994) found that since the mandate was enacted, coverage had not significantly increased in Hawaii in absolute terms. He also correctly noted that according to the Current Population Surveys, several states without mandates have smaller uninsured populations than Hawaii." *Id.*
4. 29 U.S.C.A. §1144 (1975).
5. Jolee Ann Hancock, *Diseased Federalism: State Health Care Laws Fall Prey to ERISA Preemption*, 25 CUMB. L. REV. 383, 403-04 (1995).
6. *Id.* at 404.
7. *Id.*

Two health plans dominate Hawaii's market, the Hawaii Medical Service Association ("HMSA"), a licensee of Blue Cross/Blue Shield, and the Kaiser Foundation Health Plan ("Kaiser"). HMSA currently claims 72% of the State's insureds and Kaiser, 17%.<sup>8</sup> Because of its dominant market share, HMSA presumably exerts monopoly market power in Hawaii.<sup>9</sup>

Every health plan intending to do business in the state must first win approval of the Council, as provided for by the PPHCA.<sup>10</sup> However, employees of HMSA and Kaiser (collectively representing 89% of the State's insureds) have served continuously as voting members of the Council since 1975.<sup>11</sup> HMSA and Kaiser employees only recently resigned from the Council in February 2003.<sup>12</sup> This article will discuss how the Council's former composition may have facilitated anticompetitive activity, effectively keeping competition out of the Hawaii market.

Part II of this article provides background on the PPHCA, the Council, ERISA, and the PPHCA's exemption from ERISA preemption. Part II also examines Hawaii's current healthcare market and the role of the Council in determining that market. Part III raises issues of potential monopoly behavior relating to the PPHCA and the Council. Part IV discusses possible remedies, then concludes that active state supervision of the Council is the most logical immediate solution, and finally suggests that an amendment to the PPHCA or its actual repeal should be considered as a long-term remedy.

## II. Background

### A. The PPHCA, The Council, ERISA And Its Preemption Clause, And The PPHCA's Exemption

#### 1. The PPHCA

The purpose of the PPHCA was to provide health care coverage to the greatest number of Hawaii residents.<sup>13</sup> Prior to passage of the PPHCA, a gap group<sup>14</sup> existed which was not covered by any health insurance. By mandating coverage for employees who worked twenty hours or more per week, Hawaii had a great opportunity to narrow this gap group. However, "according to the best available aggregate data, the fraction of Hawaiians with hospital benefits in 1969 (88.3%)<sup>15</sup> is essentially unchanged three decades later when compared to the percent of insured, 88.9%, in 1999<sup>16</sup>.

The PPHCA essentially set a standard for mandated health care coverage by specifying that a qualified health plan must provide "benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type . . . which have the largest numbers of the subscribers in the State."<sup>17</sup> The Council allows two types of plans to currently prevail, a comprehensive Type A (modeled after HMSA or Kaiser Health Maintenance Organization ("HMO") plans) and the less comprehensive Type B.<sup>18</sup> The PPHCA mandates the specific benefits which Type

8. Health Trends in Hawaii: A Profile of the Health Care System, 5th Edition, Hawaii Health Information Corporation, available at [http://www.healthtrends.org/research/HealthMarket\\_files/sheet001.htm](http://www.healthtrends.org/research/HealthMarket_files/sheet001.htm) (last visited Nov. 13, 2002).

9. See *United States v. United Shoe Machinery Corp.*, 110 F.Supp. 295 (D. Mass. 1953), 347 U.S. 521 (1954). In this case, a supplier of shoe machinery had garnered 75% of the market. The court held that this percentage was a factor in determining market control and the overall strength of the company, however, the court did not consider whether this percentage itself would warrant an inference of monopoly power. *Id.* See also Philip Areeda & Louis Kaplow, *ANTITRUST ANALYSIS* 565 (5th ed. 1997) in which the authors state that "[a]s a practical matter, the courts will generally regard shares of 90 percent as sufficient for unilateral monopolistic exploitation and shares of 5 or even 50 percent as insufficient. But even such rules of thumb leave an enormous range of uncertainty." See *accord id.* at 571.

It cannot be emphasized too strongly that market definition and the defendant's market share give, at best, only a suggestion of defendant's market power. . . . The courts have not stated how much power they believe to be associated with given market shares. Nor have they indicated how much power must be established as a prerequisite to a finding of liability. Market definition is customary and may provide a helpful first approximation but one should have no illusions about its meaning.

*Id.*

10. Haw. REV. STAT. §393-7(a) (1993). "The director, after advice by the prepaid health care advisory council, shall determine whether benefits provided in a plan, other than the plan of the respective type having the largest numbers of subscribers in the State, comply with the standards specified in this subsection." *Id.*

11. Telephone Questionnaire with State of Hawaii Department of Labor and Industrial Relations employee (Apr. 24, 2003). HMSA and Kaiser employees have been members of the Council continuously since 1975.

12. Telephone Questionnaire with State of Hawaii Department of Labor and Industrial Relations employee (Apr. 22, 2003). HMSA's and Kaiser's resignations became effective February 25, 2003.

13. Haw. REV. STAT. §393-2 (1993).

14. Rolanda Moore Haycox, *Strategies to Meet the Needs of the Uninsured: Can the States Respond to the Challenge?*, 27 TULSA L.J. 111, 122 (1991). "Gap group individuals are persons who: (1) have too much income to qualify for Medicaid; (2) are not insured by an employer; (3) choose not to purchase health insurance; or (4) are dependents who are not included in their parents', guardian's, or spouse's health insurance plan." *Id.*

15. Thurston, *supra* note 3, at 118. Thurston, however, suggests that

these findings do not establish that the Hawaiian mandate had no impact on coverage. In particular, due to the lack of pre- and post-program measures of coverage, Dick was not able to estimate the change in Hawaiian coverage relative to the entire United States over the time frame of the mandate. Even if Hawaii's coverage rate had not increased at all since the mandate, if it prevented a rapid decline in coverage, one would conclude that it did affect coverage rates.

*Id.*

In further explanation of the uninsured group, Thurston discusses the loopholes in mandated coverage. He states:

The following categories of workers are not required to be covered under PPHCA-1974: new hires (workers who have been employed less than four consecutive weeks); part-time workers (those who are "employed" fewer than 20 hours per week); low-earnings workers (those whose monthly wages are less than 86.67 times the hourly minimum wage); government employees; self-employed individuals; seasonal workers; and commission-only workers.

*Id.* at 120.

16. Health Trends in Hawaii, *supra* note 8, available at [http://www.healthtrends.org/research/HealthMarket\\_files/sheet001.htm](http://www.healthtrends.org/research/HealthMarket_files/sheet001.htm).

Any earlier claims of Hawaii's success in covering its uninsured can be dispelled as:

In 1999, the proportion of Hawaii residents without health insurance coverage was 11 percent, as estimated by the Census Bureau, up 25 percent from 1995 levels and 52 percent from 1990. The increase in the proportion of uninsured results, in part, from QUEST enrollment reductions, the state's flat job count, and gaps in coverage for children created when employers cover employees but not family members.

*Id.* available at [http://www.healthtrends.org/health\\_market/uninsured.html](http://www.healthtrends.org/health_market/uninsured.html).

17. Haw. REV. STAT. §393-7(a)(1993).

18. Thurston, *supra* note 3, at 120.

A & Type B plans must provide.<sup>19</sup> These include in-patient hospital care, outpatient hospital care, surgical benefits, medical benefits, diagnostic services, maternity benefits, substance abuse benefits, outpatient care, and detoxification.<sup>20</sup> However,

[t]ype B plans usually incorporate reduced coverage at lower costs, such as up-front deductibles or "existing condition" clauses. PPHCA-1974 also contains an incentive for employers to provide Type A plans: there is no requirement for employer contribution toward dependent coverage under Type A plans, while employers must pay for at least 50% of dependent premiums if they offer a Type B plan.<sup>21</sup>

Because there is an inherent incentive to avoid fronting half of the cost of dependents' insurance, and because there is little difference in premium cost between Type A and Type B plans, most employers opt for Type A plans.<sup>22</sup>

Under the PPHCA, the Director of the Department of Labor and Industrial Relations ("DLIR") is charged with administering and enforcing the PPHCA.<sup>23</sup> The Director also ultimately determines whether any health plan complies with the mandated standards established by the PPHCA.<sup>24</sup>

## 2. The Council

The Director of the DLIR is mandated to appoint a Council whose members represent medical and public health professions, consumers, and persons with experience in prepaid health care.<sup>25</sup> The Council may consist of up to seven members.<sup>26</sup> Until recently, the members included a benefit plans consultant, a hospital personnel officer, a human resources officer from the hotel industry, a physician in private practice medicine, an insurance agent, an HMSA employee, and a Kaiser employee.<sup>27</sup> A newspaper investigative report, in 2001,

noted that representatives of "Kaiser Foundation Health Plan, the largest health maintenance organization in the state, and HMSA, the largest fee-for-service provider" have been voting members of the Council.<sup>28</sup> At that time, Council members had served terms ranging from one to sixteen years.<sup>29</sup>

On January 21, 2003, a newly elected Governor Linda Lingle, in her first State of the State Address, "propos[ed] that HMSA and Kaiser Permanente be prohibited in the future from sitting on the board that recommends which insurance companies can enter the market in Hawaii."<sup>30</sup> HMSA and Kaiser both voluntarily resigned from the Council shortly after the Governor's Address.<sup>31</sup> Following this, the State of Hawaii Twenty-Second Legislature then passed, and the Governor signed, SB 665 SD1 HD2 CD1 which prohibits "a person representing a health maintenance organization under chapter 432D, a mutual benefit society issuing individual and group hospital or medical service plans under chapter 432, or any other health care organization" from membership on the Council.<sup>32</sup>

At the beginning of each year, the Council chooses the plans that will be the benchmarks for the coming year - usually an HMSA plan and Kaiser HMO.<sup>33</sup> New companies applying for approval to sell insurance in the state must provide, at a minimum, similar coverage at similar cost to the plan enrollee.<sup>34</sup> These new companies submit their applications to the DLIR, at which time departmental staff review the paperwork along with a checklist and submit them to the Council for approval.<sup>35</sup> Among the required data are: proposed premium rates, deductible amounts, stop-loss provisions, detailed coverage information regarding hospital, surgical, medical, outpatient care, maternity, and other benefits.<sup>36</sup> The Council then may recommend approval of a plan with provisos.<sup>37</sup> The Council may also reject a plan for any number of reasons.<sup>38</sup>

19. HAW. REV. STAT. §393-7(c)(1993).

20. *Id.*

21. Thurston, *supra* note 3, at 120.

22. *Id.*

23. HAW. REV. STAT. §393-31 (1993). "Except as otherwise provided in section 393-7 the director [of the DLIR] shall administer and enforce this chapter." (emphasis added) *Id.*

24. HAW. REV. STAT. §393-7(a)(1993). "The director [of the DLIR], after advice by the prepaid health care advisory council, shall determine whether benefits provided in a plan ... comply with the standards specified in this subsection." (emphasis added) *Id.*

25. HAW. REV. STAT. §393-7(d)(1993). "The prepaid health care advisory council shall be appointed by the director and shall include representatives of the medical and public health professions, representatives of consumer interests, and persons experienced in prepaid health care protection. The membership of the council shall not exceed seven individuals." *Id.*

26. *Id.*

27. Telephone Interview with John T. McDonnell, a member of the Council (Nov. 3, 2001). As of November 3, 2001, the Council members were: Paul Tom, Benefit Plans Consultants, the Council's Chair; Grace Abe, Personnel Officer of Queen's Medical Center, who serves as the Council's Vice-Chair; William Brown, Vice-President for Human Resources of Outrigger Hotels; John T. McDonnell, M.D., a physician; Michael Moss, HMSA; Claudia Schmidt, Kaiser; Shirley Wong, Principal Mutual Life Insurance Company.

28. Frank Cho, *New Health Plans Blocked*, HONOLULU ADVERTISER, Aug. 19, 2001, available at <http://the.honoluluadvertiser.com/article/2001/Aug/19/bz/bz01a.html> (last visited Aug. 19, 2001).

29. *Id.*

30. Governor Linda Lingle, An Outline of the Governor's Agenda, State of the State Address (Jan. 21, 2003), available at <http://www.hawaii.gov/gov/Members/steveb/speeches/stateofstate.html> (last visited Apr. 18, 2003).

31. Telephone Questionnaire with State of Hawaii Department of Labor and Industrial Relations employee (Apr. 22, 2003), *supra* note 12. HMSA's and Kaiser's letters of resignation were both accepted, effective February 25, 2003. As of April 22, 2003, five members of the Council remain: Paul Tom, Chair; Grace Abe; William Brown; John McDonnell, M.D.; and Shirley Wong. See also, Telephone Questionnaire with State of Hawaii Department of Labor and Industrial Relations employee, *supra* note 11.

32. S.B. 665, S.D.1, H.D.2, C.D.1, 2003 Leg., 22nd Sess. (Haw.2003).

33. Telephone Interview with John T. McDonnell, *supra* note 27.

34. HAW. REV. STAT. §393-7(1993) states that

[a] prepaid health care plan shall qualify ... if it provides for health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type ... This applies to the types and quantity of benefits as well as to limitations on reimbursability, including deductibles, and to required amounts of co-insurance.

*Id.*

35. Telephone Interview with John T. McDonnell, *supra* note 27.

36. See generally, Minutes of the Council 2000-01.

37. *Id.* For example, the Council may require that: 1) a separate emergency room deductible is removed, 2) a copayment is lowered for PPO outpatient mental illness treatment (twenty-first to twenty-fourth visits), 3) a well-child (preventive) care to age six annual maximum benefit is removed, 4) a maximum lifetime benefit is at least \$1 million regardless of age, 5) at least 120 days of hospice care are covered, 6) a doctor's office visit copayment is lowered to \$10. *Id.*

38. *Id.* For example, plans may be rejected for: 1) high out-of-pocket limit, 2) high doctor office visit copayment, 3) eligibility requirement, 4) pre-existing condition limitation, 5) maternity not covered on the same basis for all dependents, 6) special waiting period and lifetime limit for organ transplant expenses, 7) exclusion of benefits for injuries related to semi-professional or professional athletics, including practice, 8) emergency room - clarifies that non-emergency care is covered at 80% after the deductible. *Id.*

### 3. ERISA

Congress enacted ERISA to solve a nationwide problem of inadequate and failed employee pension, health, and welfare plans.<sup>39</sup> Prior to ERISA, many Americans, who had relied on these plans for retirement, found these plans failing for numerous reasons, including mismanagement and under-funding.<sup>40</sup> To solve this problem, ERISA required plan administrators to comply with certain regulations and gave employees specific rights.<sup>41</sup> Because the pension plan problem was nation-wide, Congress chose a global solution and placed almost all employee pension, health, and welfare plans under the ERISA umbrella.<sup>42</sup> ERISA was signed into law on September 2, 1974.<sup>43</sup>

### 4. ERISA's preemption clause

ERISA preempted<sup>44</sup> Hawaii's PPHCA.<sup>45</sup> Its preemption clause states that "[ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ."<sup>46</sup> This preemption of state law is "express" - specifically preempting conflicting state law.<sup>47</sup> The ERISA preemption clause has been referred to as "[p]ossibly the farthest-reaching provision in the statute"<sup>48</sup> - the ERISA "statute's 'crowning achievement'."<sup>49</sup>

ERISA's preemption clause significantly constrained many states' initiatives for health care reform.<sup>50</sup> It is remarkable that these far reaching effects of ERISA were not anticipated.<sup>51</sup> The legislative

history of the statute reveals that the preemption clause in both the original House and Senate versions was narrow in scope and would have had only a partial preemptive effect.<sup>52</sup> However, those who had a vested interest in health care reform were not involved in the discussions that led to ERISA's enactment.<sup>53</sup> "[T]he Department of Labor, which would administer ERISA, was apparently not consulted about the changes in the preemption clause. The Senate conferees were . . . responsible for health policy, but [did not discuss] the implications of preemption with their counterparts on the health subcommittee."<sup>54</sup> Special interest groups pushing the preemption clause were successful in having it introduced in the final days of conference committee deliberations.<sup>55</sup> Thus, the tremendous significance of the broad preemption clause passed unnoticed and unappreciated for its breadth.

Also remarkable about the preemption clause is that it prohibits the states from making any law regarding employee benefit plans even where federal law is silent, the so-called "regulatory vacuum."<sup>56</sup> It inhibits the states with regard to health insurance even though federal law does not regulate substantive benefits.<sup>57</sup>

The State of Hawaii created its PPHCA prior to ERISA, not anticipating any federal health care legislation.<sup>58</sup> With the passage of ERISA three months later in September 1974,<sup>59</sup> Hawaii's new PPHCA became "obviously vulnerable"<sup>60</sup> to preemption.

39. Hancock, *supra* note 5, at 385.

40. *Id.*

41. James E. Holloway, *ERISA, Preemption and Comprehensive Federal Health Care: A Call for "Cooperative Federalism" to Preserve the States' Role in Formulating Health Care Policy*, 16 CAMPBELL L. REV. 405, 416 (1994).

ERISA mandates reporting and disclosure requirements, funding, participation, and vesting requirements, and fiduciary standards in the regulation of the administration of employee benefit plans. ERISA grants employees, retirees, and their dependents the right to bring claims against employers and plan administrators; thus protecting rights and enforcing obligations owed under employee welfare and pension benefit plans. By imposing requirements upon employers and relief for retirees and employees, ERISA establishes a uniform and consistent framework for the regulation of the administration of employee benefit plans.

*Id.*

42. Michael G. Pfefferkorn, *Federal Preemption of State Mandated Health Insurance Programs Under ERISA—the Hawaii Prepaid Health Care Act in Perspective*, 8 ST. LOUIS U. PUB. L. REV. 339, 341 (1989).

43. Hancock, *supra* note 5, at 385.

44. Susan J. Stabile, *Preemption of State Law by Federal Law: A Task for Congress or the Courts?*, 40 VILL. L. REV. 1, 4-5 (1995). "Preemption is the power of the federal government to supplant state law with respect to matters the federal government has the power to regulate under the Constitution. Preemption of state law by federal law may be . . . express or implied." *Id.*

45. Hancock, *supra* note 5, at 404.

46. 29 U.S.C. §1144(a) (1975).

47. Stabile, *supra* note 44, at 5. "Express preemption occurs where a statute contains an explicit statement that addresses the preemptive effect of the statute on state law claims, rather than leaving it to the courts to decide in any given dispute whether the federal statute preempts state law." *Id.*

48. Pfefferkorn, *supra* note 42, at 339.

49. *Id.*

This clause, which operates to "supersede any and all State laws insofar as they . . . relate to employee benefit plans," has been utilized to invalidate a number of comprehensive health care insurance statutes created by the states to fill the void created by the absence of a cohesive national health insurance scheme. *Id.*

50. Stabile, *supra* note 44, at 91. "[O]verall, Congress' express pronouncements have done more mischief than good." *Id.*

51. Daniel C. Schaffer and Daniel M. Fox, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 AM. J. TAX POL'Y 47, 51-52 (1989).

The health insurers appear not to have been aware of the significance of the preemption clause for their markets. A high official of the Blue Cross Association recalled that "very little was going on because nobody saw it; nobody in the health industry understood the implications of preemption." A lobbyist for the life insurance industry recalled that even though many of his largest companies wrote health insurance, they focused on other issues than preemption in the short period between the conference committee deliberations and final passage of the bill. Similarly, an eyewitness at the Health Insurance Association of America recalled that in 1974 his organization was still concerned mainly about national health insurance, cost-containment, Professional Standards Review Organizations and the new Health Planning and Resource Development Act. Moreover, the chief lobbyist was recovering from coronary bypass surgery during the period of the final negotiations of ERISA. In sum, he recalled, "I don't think anybody was thinking of the health implications of ERISA."

*Id.*

52. Pfefferkorn, *supra* note 42, at 346-347.

53. Schaffer, *supra* note 51, at 52.

54. *Id.*

55. *Id.* at 48. "The new language, preempting state laws relating to 'any employee benefit plan' including matters not regulated by the Act, was disclosed when the conference committee report was filed ten days before Congress took final action on ERISA." *Id.* at 49.

56. *Id.* at 48.

57. *Id.*

58. HAW. REV. STAT. §393-51 (1993).

This chapter [PPHCA] shall terminate upon the effective date of federal legislation that provides for voluntary prepaid health care for the people of Hawaii in a manner at least as favorable as the health care provided by this chapter, or upon the effective date of federal legislation that provides for mandatory prepaid health care for the people of Hawaii.

*Id.*

59. Leon E. Irish and Harrison J. Cohen, *Article: ERISA Preemption: Judicial Flexibility and Statutory Rigidity*, 19 U. MICH. J.L. REF. 109, 149 (1985).

60. Sylvia A. Law, *The Changing Face of Law and Medicine in the New Millennium: Article Health Care in Hawaii: An Agenda for Research and Reform*, 26 AM. J. L. AND MED. 205, 214 (2000).

## 5. The PPHCA's exemption from ERISA

Although the federal enactment of ERISA in 1974 was immediately applicable to Hawaii, the state's challenge to ERISA preemption did not actually start until 1976.<sup>61</sup> This challenge became a long campaign to save the Hawaii PPHCA that did not end until 1983 when Congress finally granted an exemption.<sup>62</sup> It remains Congress's only exemption for statewide employer mandated health care.<sup>63</sup> This challenge began with a 1976 amendment to the PPHCA.<sup>64</sup>

In 1976, Hawaii amended the PPHCA to include the diagnosis and treatment of substance abuse as a mandated benefit.<sup>65</sup> "Employers who fail[ed] to comply with the requirements of the Hawaii Act [PPHCA] [were] enjoined from carrying on their businesses in any place in the State, and [were] liable to fines and other remedies."<sup>66</sup> Standard Oil Company, which did not cover certain mandated benefits and which had not complied with mandated reporting,<sup>67</sup> filed suit in federal court seeking an injunction,<sup>68</sup> arguing that ERISA had preempted the PPHCA.<sup>69</sup> Both the United States District Court for the Northern District of California and the Ninth Circuit Court of Appeals held that *ERISA did preempt the PPHCA*.<sup>70</sup> The U.S. Supreme Court later affirmed the lower courts' rulings.<sup>71</sup>

However, while the Standard Oil litigation was proceeding, supporters of the PPHCA continued to promote the Act both locally and nationally despite the uncertainty of whether or not it was preempted by ERISA.<sup>72</sup> On a local level, Hawaii continued to comply with the PPHCA and, in time, it "became part of the work culture of Hawaii."<sup>73</sup> On a national level, the Hawaii Congressional delegation continued in its efforts to obtain either a Congressional amendment or exemption to ERISA preemption.<sup>74</sup>

After the State lost its case in federal district court in 1977, the Hawaii senators introduced legislation to Congress, attempting to exempt the PPHCA from ERISA preemption.<sup>75</sup> They lobbied while

the State's appeal in the Ninth Circuit was proceeding.<sup>76</sup> The senators, however, encountered either ambivalence or opposition from numerous fronts including key senators, the AFL-CIO, the Business Roundtable, the ERISA Industry Committee, life and health insurance associations, the American Council on Life Insurance, and the Carter Administration and Undersecretary of Labor, Robert J. Brown.<sup>77</sup>

It has been suggested that "[t]he first Senate hearings on the exemption of Hawaii were also the first public occasion on which the history of ERISA preemption was rewritten."<sup>78</sup> Though evidence exists that Congress enacted ERISA "without specific discussion,"<sup>79</sup> the new claim was that "Congress, it seemed, had inadvertently preempted state-mandated health benefits."<sup>80</sup> Whether this was influential in persuading Congress to reconsider the PPHCA's preemption is not clear.

With persistence, the Hawaii delegation finally succeeded in its efforts and Congress voted to exempt the PPHCA from the ERISA preemption clause in 1983.<sup>81</sup> But this was not without a cost. Congress granted the exemption but expressly mandated that the PPHCA should stand as it was written in 1974, some nine years earlier, without the 1976 increase in mandated benefits to which Standard Oil had earlier objected.<sup>82</sup> Expressly preempted was "any amendment of the Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date."<sup>83</sup> Thus, Congress made exceedingly clear its reluctance to consider any future exemptions for Hawaii. Congress also explicitly stated that "the amendment made by this section shall not be considered a precedent with respect to extending such amendment to any other State law."<sup>84</sup> Again, Congress's intent was clear - it had agreed to grandfather the Hawaii PPHCA, but it was unwilling to extend any further exemptions to any of the other states.<sup>85</sup>

61. Schaffer, *supra* note 51, at 54. See also Irish, *supra* note 59, at 150.

62. For a report of the Hawaii Congressional delegation's activities and the responses to their efforts to win an ERISA preemption exemption, see, e.g., Schaffer, *supra* note 51, at 53-60. See also, *ERISA: Exemption from Preemption for Hawaii Prepaid Health Care Act*: Hearing on H.R. 4046 Before the Subcomm. on Labor-Management Relations of the Comm. on Education and Labor, 97th Cong. 2d Sess. 3 (1982).

63. Schaffer, *supra* note 51, at 54.

64. *Id.*

65. *Standard Oil Company of California v. Aghsalud*, 442 F. Supp. 695, 696 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981). See also Schaffer, *supra* note 51, at 54.

66. *Standard Oil Company of California*, 442 F. Supp. at 696.

67. *Id.*

68. *Id.* at 697. See also Schaffer, *supra* note 51, at 54.

69. *Standard Oil Co. of California*, 442 F. Supp. at 697.

70. *Standard Oil Co. of California*, 663 F.2d at 766.

71. *Aghsalud v. Standard Oil Company of California*, 454 U.S. 801 (1981).

72. Law, *supra* note 60, at 214.

73. *Id.* Even after Congress overturned the PPHCA, most employers voluntarily continued to provide coverage for employees. *Id.*

74. Schaffer, *supra* note 51, at 54-59.

75. *Id.* at 54-55.

76. *Id.*

77. *Id.* at 55-57.

78. *Id.* at 57-58.

79. *Id.* at 58 (quoting Renfrew, J. in *Standard Oil Co. of California v. Aghsalud*, 442 F. Supp. 695, 711 (N.D. Cal. 1977)).

80. Schaffer, *supra* note 51, at 58. Apparently Senator Daniel Inouye had misquoted Judge Renfrew, and in doing so, he suggested that the preemption of Hawaii's PPHCA was simply inadvertent. *Id.*

81. *Id.* at 59.

82. *Id.*

83. 29 U.S.C. §1144(b)(5)(B)(iii)(1983)(emphasis added).

84. Schaffer, *supra* note 51, at 59 (quoting Pub. L. No. 97-473, sec. 301(b), 96 Stat. 2605, 2612 (1983)(not codified)).

85. Schaffer, *supra* note 51, at 59.

## B. The Current Health Care Market

As noted earlier, HMSA and Kaiser dominate the market. HMSA, a non-profit tax-exempt mutual benefit society,<sup>86</sup> "wields monopoly power as a seller of health insurance, and monopsony<sup>87</sup> power as a purchaser of the services of health care providers."<sup>88</sup> In 1977, HMSA provided coverage for 44.3% of people in the private sector and served as the third party administrator for Medicare and several other health plans.<sup>89</sup> Kaiser, HMSA's closest competitor, provided coverage for only 14.7% of the private sector.<sup>90</sup> In 1999, more than 60% of consumers were covered by HMSA,<sup>91</sup> and estimates for 2000, are closer to 72%.<sup>92</sup> As these figures indicate, "HMSA has enormous capacity to exercise control."<sup>93</sup> Undoubtedly, HMSA is a dominant market player and has enormous marketing power which makes Hawaii, for all practical purposes, "a single payor health insurance system"<sup>94</sup> and a monopoly health care market.

According to Professor Richard S. Miller, Professor of Law, Emeritus, William S. Richardson School of Law,<sup>95</sup> HMSA "virtually monopolizes the Preferred Provider Organizations (PPOs) and is almost the only buyer of physicians' PPO services in this State . . ."<sup>96</sup> Indeed, the participating provider agreement, which physicians must sign in order to contract with HMSA, was characterized as a contract of adhesion in 1999, by Arleen Meyers, M.D., J.D., founder and President of the Hawaii Coalition for Health ("Coalition"), a non-profit health care consumer advocacy organization.<sup>97</sup>

In 1999, the Coalition filed a complaint with Hawaii's Insurance Commissioner against HMSA. The following discussion of the Coalition's complaint is not offered in this article as legal authority, but to describe an aspect of the current health care market that has recently raised some antitrust concern. The Coalition's complaint alleged "unfair contracting practices and creating a business environment of adhesion, coercion, and intimidation and for exercising its monopsony power to unreasonably restrain physicians' ability to provide quality care for their patients or to advocate on behalf of their patients . . ."<sup>98</sup> As regards HMSA and its provider contract,

Dr. Meyers stated that

HMSA occupies more than sixty percent (60%) of the consumer market for health insurance and is the major payor of reimbursements for medical care for virtually all Hawaii physicians who are not fully employed by a single health maintenance organization. If physicians practicing outside the Kaiser Permanente system don't sell their services to HMSA, they are forced to go out of business. As a result, physicians are under enormous economic pressure to enter into any contract proffered by HMSA regardless of whether the terms are anti-competitive or against their or their patients' individual self-interest. *HMSA therefore holds both monopoly and monopsony power of dangerous proportions*, precluding any single physician's ability to negotiate with HMSA for either herself or her patients.<sup>99</sup>

In response, HMSA argued that health care contracts between HMSA and its providers were private contracts and not under the regulation of the Insurance Commissioner.<sup>100</sup>

The Coalition's complaint was settled in 2000.<sup>101</sup> HMSA agreed to "significant changes in the appeals processes it provides to physicians, while the Commissioner accepted HMSA's assertion that federal law prohibits state regulation of contracts between insurers and providers."<sup>102</sup>

## III. Antitrust Issues

This section will discuss potential antitrust issues and monopoly behavior, however, it must again be noted that the scope of this article does not permit a detailed antitrust analysis. The discussion in this section deals with the Council's implementation of the PPHCA and the Act's regulatory limitations.

Of note, HMSA and Kaiser representatives were first appointed to the Council in 1975, when the PPHCA was initially implemented, and served continuously on the Council until February 25, 2003, when they voluntarily resigned.<sup>103</sup> HMSA's membership on the Council for the past three decades created an extraordinary conflict of interest and facilitated potential anticompetitive activity on the

86. About HMSA, at <http://www.hmsa.com/company/about.html> (last visited Oct. 24, 2001).

87. BLACK'S LAW DICTIONARY 1023 (17th ed. 1999). Monopsony is "[a] market situation in which one buyer controls the market." *Id.*

88. Law, *supra* note 60, at 210.

89. *Id.*

90. *Id.* "HMSA's only serious competitor is Kaiser, which served 14.7% of people with private health insurance in 1997. In 1997, all other commercial insurers combined provided coverage to only 2.6% of the population." *Id.*

91. Hawaii Coalition for Health v. Hawaii Medical Service Assoc., Complaint to the Ins. Div., Dep't of Commerce and Consumer Affairs, State of Hawaii, October 27, 1999, at 1.

92. Health Trends in Hawaii, *supra* note 8.

93. Law, *supra* note 60, at 210.

94. *Id.*

95. Richard S. Miller, J.D., is also Legal Consultant to the Hawaii Coalition for Health.

96. Richard S. Miller, *Why We Need Laws to Protect Patients from Their Health Plan*, HAWAII MEDICAL JOURNAL, February 2000, at 70.

97. Hawaii Coalition for Health v. Hawaii Medical Service Assoc., Complaint to the Ins. Div., Dep't of Commerce and Consumer Affairs, State of Hawaii, Oct. 27, 1999, at 2. This complaint was written by Arleen Meyers, M.D., J.D., a previous student of Professor Richard S. Miller.

98. *Id.* at 1.

99. Hawaii Coalition for Health, *supra* note 91, at 1 (emphasis added).

100. Law, *supra* note 60, at 212.

101. *Id.*

102. *Id.*

103. Telephone Questionnaire with State of Hawaii Department of Labor and Industrial Relations employee, *supra* note 11. See also, Telephone Questionnaire with State of Hawaii Department of Labor and Industrial Relations employee, *supra* note 12.



part of HMSA. New companies applying to do business in the state were obligated to submit applications and divulge proprietary and confidential information to the Council.<sup>104</sup> While most new plans would have guarded this information from prospective competitors, the information instead went directly to HMSA and Kaiser employees by virtue of their membership on the Council.<sup>105</sup> On occasion, this information also went to more than one HMSA or Kaiser employee in attendance at meetings of the Council.<sup>106</sup> Data summary sheets, usually generated at each Council meeting, assisted a comparison of benefits between plans.<sup>107</sup> Even a member of the Council itself "acknowledge[d] that by being on the council the two companies [HMSA and Kaiser] may be getting 'a leg up' on their competitors by seeing their plans . . ."<sup>108</sup> It is likely that this loss of confidentiality was a strong deterrent to new market entrants - possibly serving to maintain Hawaii's contracted health care market.

Remarkably, previous directors of the DLIR and previous Council chairs allowed and even required the sharing of this proprietary information among market competitors. HMSA and Kaiser may have had an unfair advantage if their employees who were Council members directly relayed proprietary information belonging to new health plan applicants. There was certainly potential for violating a basic goal of antitrust law - fairness and elimination of unfair business practices.<sup>109</sup>

The primary statute that is the basis for federal antitrust law is the Sherman Act.<sup>110</sup> Section 1 of the Sherman Act declares that activity in restraint of trade is illegal and those who participate in such activity will be found guilty of a felony punishable by fine and/or imprisonment or may be subject to damage claims.<sup>111</sup> Section 2 relates to independent conduct and states that "[e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony" punishable by fine and/or imprisonment, or may be subject to damage claims.<sup>112</sup>

Areeda defines monopoly power "as the power to control price or to exclude competition. It can be understood as a significant degree of market power."<sup>113</sup> Market power, in turn, is "the capacity to act other than as would a perfectly competitive firm. In particular, most discussions of market power will concern the extent to which a firm's most profitable price exceeds competitive price levels."<sup>114</sup> However, market power may also "be inferred from structure, conduct, performance, or some combination of the three."<sup>115</sup> Areeda notes that "[d]ebate over §2 often contrasts power with conduct, structure with behavior."<sup>116</sup>

In *United States v. Aluminum Co. of America* ("ALCOA"),<sup>117</sup> ALCOA was alleged to have monopolized the interstate commerce of aluminum. The case came before Judge Learned Hand of the United States Circuit Court of Appeals, Second Circuit, via a certificate of the Supreme Court.<sup>118</sup> The court held that a monopoly itself is not evidence of monopolizing and that ALCOA "may not have achieved monopoly; monopoly may have been thrust upon it."<sup>119</sup> The court then drew a distinction between "power and conduct, structure and behavior"<sup>120</sup> by stating "that size does not determine guilt; that there must be some 'exclusion' of competitors; that the growth must be something else than 'natural' or 'normal'; that there must be a 'wrongful intent,' or some other specific intent; or that some 'unduly' coercive means must be used"<sup>121</sup> in order to constitute an antitrust offense.

Similarly, in *United States v. Grinnell Corp.*,<sup>122</sup> the defendant had high market power consisting of "over 87% of the business."<sup>123</sup> "The percentage is so high as to justify the finding of monopoly. And, as the facts already related indicate, this monopoly was achieved in large part by [sic] unlawful and exclusionary practices."<sup>124</sup> Justice Douglas stated that "[t]he offense of monopoly . . . has two elements: (1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historical accident . . ."<sup>125</sup>

104. Telephone Interview with Edward T. Coda, President of Med\*Save Hawaii Marketing, Inc. ("Med\*Save"), a representative of a health plan rejected by the Council (Nov. 20, 2001). Med\*Save had hoped to market medical savings accounts, also known as medical IRAs (individual retirement accounts). It submitted a "complete copy" of its plan to the PPHCC. It had paid "significant dollars to actuaries to develop a rate structure used in coming up with information with submitting our plans." *Id.* When the submitted plan was rejected, there was concern that this information could be used by others to create a similar plan in Hawaii or elsewhere on the mainland. *Id.*

105. *Id.* The information that Med\*Save provided to the Council included, but is not limited to, the following: estimated costs of providing customer service, employer group contracts, provider contracts, anticipated market share, commission rates, third party administrator information, and therefore, indirectly, provider fee schedules. *Id.*

106. Telephone Interview with John T. McDonnell, *supra* note 27.

107. See Minutes, *supra* note 36. This data includes such information as: eligibility requirements, waiting periods, premium amounts, deductible amounts, out-of-pocket limits, stop-loss provisions, limits on pre-existing conditions, hospital coverage, surgical benefits, medical benefits (including number of home and office visits), out-patient care benefits, maternity benefits, diagnostic and other benefits. *Id.*

108. Cho, *supra* note 28 (quoting William S. Brown, Vice-President for Human Resources, Outrigger Hotels).

109. Areeda, *supra* note 9, at 26. Additionally, even with proposed changes relating to their own plans, HMSA and Kaiser representatives remained at the table and actively participated in discussion - they did not vote but remained present at the vote. (Telephone Interview with John T. McDonnell, *supra* note 27).

110. Areeda, *supra* note 9, at 4. "The basic statute, the Sherman Act, simply condemns (1) contracts, combinations, and conspiracies in restraint of trade and (2) monopolization, combinations and conspiracies to monopolize, and attempts to monopolize." *Id.*

111. 15 U.S.C. §1 (LEXIS Law Publishing 2001).

112. 15 U.S.C. §2 (LEXIS Law Publishing 2001).

113. Areeda, *supra* note 9, at 448.

114. *Id.*

115. *Id.*

116. *Id.* at 447.

117. 148 F.2d 416 (2d Cir. 1945).

118. *Id.* at 421.

119. *Id.* at 429.

120. See *supra* note 114.

121. *Aluminum Co. of America*, 148 F.2d at 429.

122. 384 U.S. 563, 570-71 (1966).

123. *Id.* at 567.

124. *Id.* at 576.

125. *Id.* at 570-71 (emphasis added).

HMSA, covering 72% of insureds in a market analysis, would likely be found to have monopoly power, but monopoly power itself does not violate antitrust law if it has been legally obtained.<sup>126</sup> However, if the HMSA and Kaiser employees who served on the Council voted to reject competitor plans for reasons other than furthering the lawful purposes of the Council, or if HMSA and Kaiser benefited from knowledge of proprietary information gained through the Council, then this conduct could constitute behavior consistent with illegal maintenance of a monopoly.

According to an investigative report of a major local newspaper published in 2001, the previous Council rejected ninety-six out of an approximate one hundred mainland plans that applied to do business in Hawaii.<sup>127</sup> Fifty-nine out of sixty-four plans were rejected in the first seven or eight months of 2001.<sup>128</sup> In the same article, Professor Thomas Saving, Professor of Economics, Texas A & M University,<sup>129</sup> stated, "I don't think there is much doubt that they (HMSA and the council) are deterring entry into the market."<sup>130</sup> It is essential that recent Council denials be scrutinized and an assessment made of procedures to safeguard the confidentiality and disclosure of proprietary information.

Although it is imperative that the State of Hawaii provide adequate supervision of the Council, as Professor Richard S. Miller recognized, there was "only the most minimal of scrutiny and supervision"<sup>131</sup> by the state's DLIR. By permitting HMSA and Kaiser seats on the Council, previous DLIR directors created a convenient mechanism for market competitors to control new entry into the Hawaii market and thus may have facilitated potential monopoly antitrust activity. Furthermore, other individuals who were present at Council meetings, including HMSA and Kaiser employees who were not members of the Council, had the opportunity to use proprietary information discussed at these meetings. New applicants may have been deterred from even applying to do business in the state when

they realized that they were required to share their information with major market competitors, and without any guarantee that a license to sell insurance would even be granted. The bottom line is that HMSA and Kaiser employees should not have served as Council members because of their inherent conflicts and the appearance of impropriety. Informational firewalls should be enacted immediately if they do not yet exist. The newly constituted Council in 2003 must consider potential conflicts of interest at the same time it reconciles itself with Hawaii's sunshine laws.

In response to criticism that the State has *not* provided adequate oversight, the previous Administration and HMSA may both raise an argument of state action immunity.<sup>132</sup> However, in order to claim the protection that state action immunity carries, there must be, on the part of the State, "adequate supervision and [a] clearly articulated purpose to displace competition"<sup>133</sup> which appear to be lacking here. Instead, here, there appears to have been a general abdication of the State under successive previous administrations to provide oversight.<sup>134</sup>

There may also have been an unusually close working relationship between the DLIR and HMSA, raising a question of propriety. A previous DLIR director resigned her position as DLIR director in October, 2000,<sup>135</sup> was elected Chair of the Hawaii Democratic Party in April, 2001, and was then elected to the Board of Directors of HMSA in May, 2001.<sup>136</sup> Scrutiny must be applied to the Council's activities, its voting members, and the State's supervisory role via the DLIR to insure that all business is conducted with the acknowledgment of conflicts of interest and with the assurance of propriety and fair dealing.

The potential monopoly problem is further compounded by a general requirement of the PPHCA which specifies that any plan operating in the state shall provide "health care benefits equal to, or medically reasonably substitutable for, the benefits provided by

126. Aluminum Co. of America, 148 F.2d at 430. "The successful competitor, having been urged to compete, must not be turned upon when he wins." *Id.*

127. Cho, *supra* note 28.

128. Cho, *supra* note 28.

129. Thomas Saving, Ph.D., is Director of Private Enterprise Research Center at Texas A&M. "In 2000, President Clinton appointed Dr. Saving to the Board of Trustees of the Social Security and Medicare Trust Funds. In May 2001, he was appointed by President Bush to the President's Commission to Strengthen Social Security." Private Enterprise Research Center (Nov. 30, 2002) at <http://www.tamu.edu/perc/staff.html>.

130. Cho, *supra* note 28.

131. Miller, *supra* note 96, at 70. See also Areeda, *supra* note 9, at 129. For state action immunity, there must be, on the part of the State, "adequate supervision and [a] clearly articulated purpose to displace competition" which appear to be lacking here. *Id.*

132. See Philip A. Proger, *Antitrust Primer*, presented at a meeting of the American Health Lawyers Association: Antitrust in the Healthcare Field held February 17-18, 2000, Arlington, VA, at 83-84.

The state must reasonably have foreseen that anticompetitive effects logically would result from its announced policy." Furthermore, anticompetitive activity of even a private party may be immune if the party can prove that "not only was it acting pursuant to clearly articulated and affirmatively expressed state policy but also that the state was actively supervising its anticompetitive conduct. *Id.* (emphasis added).

State action immunity has four broad categories: 1) federal immunity; 2) state immunity; 3) state action immunity of local governments, including municipalities; and 4) state action immunity for private parties.

In the health care sector, as well as in other others [sic], the federal government is immune from liability under the Sherman Act. This immunity extends to intermediaries and agents acting on behalf of the government. . . . Actions of the sovereign branches of a state – the legislature, the highest state court and presumably the executive – are immune as well. . . . Under our dual federal system of a sovereign federal government and sovereign states, local subdivisions of the state and other state agencies and municipalities are not automatically immune from antitrust liability unless their allegedly anticompetitive acts are authorized by the state. When they act pursuant to a 'clearly articulated and affirmatively expressed' state policy to displace competition with regulation in a particular industry, their actions are immune. *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389 (1978)(municipal activities in operating city-owned electric utilities not immune from antitrust attack because of the absence of any state policy displacing competition with regulation or monopoly public service or authorizing anticompetitive conduct....The state must reasonably have foreseen that anticompetitive effects logically would result from its announced policy.

*Id.* at 83-84.

133. Areeda, *supra* note 110, at 129.

134. Proger, *supra* note 132, at 84.

Under appropriate circumstances, private parties, as well as government agencies, may be immune from antitrust liability. If the allegedly anticompetitive conduct is the action of a private party, rather than a government entity, the private party must prove not only that it was acting pursuant to clearly articulated and affirmatively expressed state policy but also that the state was actively supervising its anticompetitive conduct.

*Id.* (emphasis added).

135. Telephone Questionnaire with State of Hawaii Department of Labor and Industrial Relations employee (June 30, 2003), *supra* note 12.

136. This previous DLIR director, appointed by Governor Benjamin Cayetano, remained in that position for five years until she left the DLIR and joined a private Honolulu law firm. She was elected Chair of the Hawaii Democratic Party shortly thereafter on April 16, 2001. Lynda Arakawa, *Democrats Elect Leader*, HONOLULU ADVERTISER, April 17, 2001, available at <http://the.honoluluadvertiser.com/article/2001/Apr/17/In/In08a.html> (last visited Oct. 24, 2001).

A month later, in May 2001, she was elected to the Board of Directors of HMSA. *Trade Winds*, HONOLULU ADVERTISER, May 21, 2001, available at <http://the.honoluluadvertiser.com/article/2001/May/21/bz/bz10atradewinds.html> (last visited Oct. 24, 2001).



prepaid health plans of the same type . . . which have the largest numbers of subscribers in the State.”<sup>137</sup> Because HMSA is the plan with the largest number of insureds, any new market player is mandated to provide the same package of benefits that HMSA provides. However, in order to compete successfully with HMSA, the new plan must provide these benefits at similar or lower cost or must offer some other value added benefit. Since HMSA has monopoly (dominant market share for selling its plans) and monopsony (monopoly buying) power<sup>138</sup>, it is highly unlikely that any new player can compete successfully with HMSA.<sup>139</sup>

Any value added benefit or innovation that a new applicant might have hoped to use to compete with HMSA would have been divulged to the previous Council, and from there, potentially directly to HMSA and Kaiser. Even with HMSA and Kaiser no longer seated as Council members, their presence in the public audience at Council meetings may continue to serve as a deterrent to new applicants.

The Council wields significant power. Even if a new applicant offers a promising, new, and strikingly innovative plan (for example, medical savings accounts or medical IRAs), the Council can still reject it, and opt to maintain the status quo. In the past, the rationale used to justify denial of medical savings account plans was that, although the new plans would provide comprehensive coverage with similar employee out-of-pocket expenses, the coverage would not be the same as the Council’s benchmark plans (HMSA and Kaiser).<sup>140</sup>

In the past few years, several health plans have closed their doors,<sup>141</sup> unable to sustain business in Hawaii’s market. These plans were unable to successfully compete with HMSA. In some cases, the plans set low premium rates in order to compete, however these premium levels were probably too low to cover the costs of doing business. Few start-ups have assets, reserves, or investment income that are sufficient enough to offset initial operating losses.<sup>142</sup> Additionally, few plans can compete in Hawaii because of the generally higher costs associated with mandated benefits.<sup>143</sup>

It is vitally important to understand that, despite operating losses of its health plans, HMSA has, until recently, been able to report yearly net gains because its losses have been offset by relatively huge returns on investments. HMSA had \$37 million in operating losses in 1998, \$18 million in 1999, and \$49 million in 2000.<sup>144</sup> However, these losses were offset by investment income of \$54 million in

1998, \$57 million in 1999, and \$66 million in 2000.<sup>145</sup> Thus, HMSA has had tremendous financial ability to offset operating losses with investment income. This record shows that HMSA likely offered premiums below the cost of doing business, and health plans that did not have the financial depth of HMSA went out of business.

However, HMSA is not immune to general economic conditions, especially as relates to investment income. For 2002, HMSA has now reported losses of “\$34.9 million, compared with a \$3.4 million gain in 2001 . . . . Those losses were worsened by a \$21.3 million one-time charge [for technology upgrades] . . . . Excluding the one-time charges, HMSA’s net loss for 2002 was \$13.6 million.”<sup>146</sup> During that same period, HMSA reported investment income of \$2.6 million. Now, for the first quarter of 2003, HMSA has already reported a net income of \$3.7 million.<sup>147</sup> Few companies have HMSA’s ability to weather economic downturns.

Through continuing monopoly power, large assets, and knowledge of other plans’ proprietary information, HMSA has had the requisite ability to offer below cost pricing. This has resulted in few competitors and little choice for consumers who now face a very contracted market. The situation is ripe for a Section 2 Sherman Act violation for illegal maintenance of a monopoly, and immediate intervention is important to determine whether any such conduct has already occurred.

In 2000 and 2001, soon after other health plans that were unable to sustain business left the market, HMSA increased its premiums 8.5% and 9% respectively. In 2002, HMSA announced yet another rate increase of 5% for small employer groups and 7% for HMSA Health Plan Hawaii, its HMO (health maintenance organization) plan. In 2003, HMSA announced it would seek approval for an 11.5% rate increase for small businesses for its Preferred Provider Plan and a 7.8% rate increase for its Health Plan Hawaii Plus.<sup>148</sup> Scrutiny can be applied now, to ascertain whether HMSA became financially stronger simply through good business management or whether predatory pricing<sup>149</sup> has occurred.

In sum, there is no substantial competitor to HMSA in Hawaii. The regulatory limitations of the PPHCA and the previous decisions of the Council, influenced by HMSA and Kaiser serving as members, may have played important roles in preserving HMSA’s dominant position.

137. HAW. REV. STAT. §393-7(a) (1993).

138. Law, *supra* note 60, at 210.

139. Cho, *supra* note 28 (quoting Professor Thomas Saving).

140. Telephone Interview with Edward T. Coda, *supra* note 104.

141. Telephone Questionnaire with State of Hawaii Department of Commerce and Consumer Affairs employee (November 2002). During 1998 and 1999, three plans (Queen’s Premier Plan, Pacific Health Care, and Kapiolani Health Hawaii) either dissolved or changed in corporate structure. Insureds covered under Queen’s Premier Plan were transferred to HMSA’s Health Plan Hawaii (“HPH”) in October 1998. Pacific Health Care closed its doors and transferred its patients to HMSA HPH in August 1999. Kapiolani Health Hawaii’s three HMO [health maintenance organization] plans were bought out by HMSA HPH in November 1999. A fourth health plan, University Health Alliance, was in receivership with the State’s Insurance Commissioner.

142. As a practicing physician and surgeon, this author has found physicians naturally reluctant to participate with new plans because new plans may require medical providers to share risk when there is concern that the plans themselves may be undercapitalized.

143. Cho, *supra* note 28 (quoting Thomas Saving, see *supra* note 128, and accompanying text).

144. Helen Altonn, *HMSA Rates Set to Rise*, HONOLULU STAR-BULLETIN, May 3, 2001, available at <http://starbulletin.com/2001/05/03/news/index.html> (last visited Aug. 26, 2001).

145. *Id.*

146. John Duchemin, *HMSA’s Losses Worst Ever*, HONOLULU ADVERTISER, Feb. 28, 2003, available at <http://the.honoluluadvertiser.com/article/2003/Feb/28/bz01a.html> (last visited Apr. 10, 2003).

147. John Duchemin, *HMSA Reverses Its Loss Trend*, HONOLULU ADVERTISER, May 13, 2003, available at <http://the.honoluluadvertiser.com/article/2003/May/13/bz09p.html> (last visited June 29, 2003).

148. For community-rated groups, HMSA raised rates an average of 8.5% in 2000, and 9% in 2001. On May 7, 2002, HMSA announced a rate increase of 5% for small employer groups, and 7% for basic medical plans for HMSA Health Plan Hawaii. Lyn Danninger, *Small Businesses To See HMSA Hike*, HONOLULU STAR-BULLETIN, May 8, 2002, available at <http://starbulletin.com/2002/05/08/news/story2.html> (last visited Aug. 8, 2001).

Just one year later, in 2003, HMSA announced that it would seek approval for an 11.5% rate increase applicable to small businesses for its Preferred Provider Plan, and a 7.8% rate increase for Health Plan Hawaii Plus (its largest HMO plan). John Duchemin, *HMSA Seeking 11.5% Increase For Businesses*, HONOLULU ADVERTISER, April 8, 2003, available at <http://the.honoluluadvertiser.com/article/2003/Apr/08/bz02a.html> (last visited Apr. 10, 2003).

149. Areeda, *supra* note 9, at 914 (citing Brooke Group Ltd. v. Brown & Williamson Tobacco Corp., 509 U.S. 209 (1993)). Predatory pricing under Section 2 of the Sherman Act has two prerequisites to recovery . . . . First, a plaintiff seeking to establish competitive injury resulting from a rival’s low prices must prove that the prices complained of are below an appropriate measure of its rival’s costs . . . . The second prerequisite to holding a competitor liable under the antitrust laws for charging low prices is a demonstration that the competitor had a reasonable prospect, or, under §2 of the Sherman Act, a dangerous probability, of recouping its investment in below-cost prices . . . .

*Id.*

## IV. Remedies

### A. State Government

The most expeditious remedy to correct an environment so conducive to antitrust activity has already occurred under the new state administration. In her first State of the State address in January, 2003, Governor Linda Lingle expressly made known her desire for a Council excluding HMSA and Kaiser, and HMSA and Kaiser quickly resigned as members of the Council.<sup>150</sup> This immediately conveyed a new sense of fairness to the application and approval process and portends greater supervision of the Council's activities. With these assurances, new competitors can now be encouraged to enter the Hawaii market. Similarly, the public can be assured that the Council will deliberate fairly, and the public will benefit from new competition in the health care market.

The bigger question, however, remains - does the ERISA preemption allow the PPHCA to evolve and address the new demands of Hawaii's current health care market? Several authorities<sup>151</sup> suggest "ERISA now severely limits Hawaii's ability to improve its health care system, since Hawaii cannot amend its 1974 legislation to implement more comprehensive and effective reforms."<sup>152</sup> The PPHCA is frozen in time, permanently set in a 1974 mindset with little possibility of amendment. "[T]he Congressional action that saved the Hawaii Act from preemption also effectively removed the ability of the Hawaii legislature to modify it."<sup>153</sup> The PPHCA is virtually impossible to change as expressly stated in the preemption waiver.<sup>154</sup> Thus, the Hawaii State Legislature is significantly precluded from addressing current health care needs.<sup>155</sup>

This bar to innovation prevents creative responses to Hawaii's changing health care demographics. This is a significant problem. The Hawaii Health Information Corporation, reporting health related

data since 1994, cites several areas of concern. These include a rapidly increasing elderly population, exponentially growing costs of chronic care, the shifting of health care coverage to managed care plans, and a higher rate of inflation for medical care.<sup>156</sup> Costs for chronic care alone are expected to double over the next two decades and, in the year 2020, are expected to account for 80% of total direct expenditures.<sup>157</sup>

Entities with vested interests in access to health care are aware of these evolving needs and the inadequacy of Hawaii's current system to address them. Even a Council member recently said, "[t]he market has so changed over the years that the Prepaid Health Care Act is antiquated beyond its usefulness."<sup>158</sup> Despite earlier attempts of the State to win Congressional approval to change the PPHCA, those efforts have been consistently rebuffed.<sup>159</sup>

Indeed, "[i]n the 1990s, Congress considered a number of proposals for expansive ERISA waivers. Hawaii, among other states, sought additional waivers that would allow the state to modify its health care laws . . . . Congress has repeatedly demonstrated its unwillingness to extend ERISA waivers for Hawaii."<sup>160</sup> This is regrettable, especially in light of evidence that the PPHCA was conceived with the understanding that it would need to be extended to other patient groups if it proved to be successful.<sup>161</sup> The State had realized, at inception, that gap groups would initially exist, and had provided a scheme to be implemented later, which would allow the subsequent inclusion of these gap groups (the self-employed and others).<sup>162</sup> Although the ERISA preemption and exemption clauses preclude changes to the PPHCA, on close scrutiny, a solution may be found buried within the language of ERISA itself.

Despite the general statutory limitation of ERISA's section 514(a), states caught by ERISA preemption may possibly have two options to develop their own health care initiatives.<sup>163</sup>

150. See *supra* notes 30-31.

151. See, e.g., Byron Done, *Health Care Reform and ERISA Preemption: Can the States Adopt Aspects of Germany's Health Care System to Achieve Universal Access and Cost Containment?*, 18 HASTINGS INT'L & COMP. L. REV. 745, 757 (1995).

152. *Id.*

153. Pfefferkorn, *supra* note 42, at 364.

154. See *supra* note 83.

155. Hancock, *supra* note 5, at 404.

156. The Hawaii Health Information Corporation ("HHIC") has been reporting health data since 1994 via both publication and website with the sponsorship of HMSA. Regarding demographic changes, it reports that Hawaii's population is aging rapidly . . . . The numbers of the "older old" are also increasing dramatically . . . . The increasing proportion . . . signals the need to monitor the ability of health care resources to meet the elderly's greater need for services . . . . The portion of the population deemed of "work age" (19-65) is decreasing relative to the elderly, raising questions about the social burdens this decreasing cohort must bear . . . . posing important questions for health care and public policy.

Health Trends in Hawaii, *supra* note 8, available at <http://www.healthtrends.org/demographics/index.html> (last visited Nov. 13, 2002).

Regarding chronic diseases, HHIC reports:

Chronic diseases include conditions that are prolonged, do not resolve spontaneously and are rarely cured completely . . . . approximately 45 percent of the U.S. population suffers from some type of chronic condition. The direct cost for chronic care in 2000 was \$510 billion. This is expected to double by 2020 and account for 80 percent of direct medical expenditures.

*Id.* available at [http://www.healthtrends.org/health\\_status/chronic.html](http://www.healthtrends.org/health_status/chronic.html) (last visited Nov. 13, 2002).

Regarding an overview of the health care market, HHIC states:

Managed care has replaced traditional fee-for-service or indemnity reimbursement to providers as the principal system of managing and financing health care delivery. In 2000, 85 percent of insured Hawaii's [sic] residents were covered under some form of managed care program, an increase of 49.1 percent from 1992. As coverage shifts away from traditional fee-for-service coverage and indemnity insurance, which declined by 62.5 percent from 1992, mainland commercial insurers play a diminishing role in Hawaii's market.

*Id.* available at [http://www.healthtrends.org/health\\_market/index.html](http://www.healthtrends.org/health_market/index.html) (last visited Nov. 13, 2002).

"Since the advent of QUEST [Hawaii Medicaid HMO] in 1994, total HMO enrollment increased by 48.5 percent. When QUEST plans are excluded, enrollment in HMOs increased by 68 percent over the same period." *Id.* available at [http://www.healthtrends.org/health\\_market/managed\\_care.html](http://www.healthtrends.org/health_market/managed_care.html) (last visited Nov. 13, 2002).

"Over the 1990s, the average inflation rate for medical care was 72 percent higher than the overall inflation rate." *Id.* available at [http://www.healthtrends.org/health\\_market/cpi.html](http://www.healthtrends.org/health_market/cpi.html) (last visited Nov. 13, 2002).

157. *Id.*

158. Cho, *supra* note 28 (quoting William Brown, Vice-President of Human Resources for Outrigger Hotels Hawaii).

159. Fernando R. Laguarda, *Federalism Myth: States as Laboratories of Health Care Reform*, 82 GEO. L.J. 159, 183 (Nov. 1993).

160. Devon P. Groves, *ERISA Waivers and State Health Care Reform*, 28 COLUMB. J.L. & SOC. PROBS. 609, 634-35 (1995).

161. Pfefferkorn, *supra* note 42, at 364-65.

162. *Id.* at 365.

163. Groves, *supra* note 160, at 620-24.

## Specifically the Act in

[s]ection 514(a) . . . declares that ERISA "supersedes any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" (including ERISA-covered health plans). However, Section 514(b) qualifies this by explicitly preserving state regulation of 1) "insurance, banking, or securities" 2) "generally applicable criminal laws[s] of a State" and 3) the Hawaii Prepaid Health Care Act as amended through September 2, 1974.<sup>164</sup>

States, using a narrow interpretation of section 514(a)'s "relates to" clause, may enact generally applicable legislation that escapes the "relates to" clause or, alternatively, they may use the "savings clause" of section 514(b) that preserves the states' ability to regulate insurance.<sup>165</sup>

The "relates to" clause, if narrowly interpreted, may exempt statutes of general applicability. In *United Wire, Metal and Machine Health and Welfare Fund v. Morristown Memorial Hospital*,<sup>166</sup> employee benefit plan participants sued to upset New Jersey's method for determining hospital rates.<sup>167</sup> The Third Circuit held that the hospital's rate setting scheme was not preempted by ERISA because it related to a "statute of general applicability."<sup>168</sup> The Supreme Court upheld this ruling.<sup>169</sup>

The "savings clause" of ERISA stems from Congress's original intent that the states continue to regulate insurance even after ERISA's enactment.<sup>170</sup> Congress specifically "'saved' state laws that regulate insurance, banking, and securities."<sup>171</sup> The ERISA savings clause exempts state laws "'to the extent they are applied to insurance companies or insurance policies, even if they might impact on employee benefit plans.'"<sup>172</sup> This, in effect, leaves open a window for state insurance regulation. Examples include workers' and unemployment compensation and disability insurance.<sup>173</sup> Thus, the Hawaii State Legislature may be able to use the ERISA savings clause to uphold the state's prerogative to regulate certain aspects of insurance. The courts may provide additional support.

## B. Judicial Review

For many years, the specific language of the express preemption left little room for judicial maneuvering.<sup>174</sup> ERISA's broad preemption explicitly states that it preempts "'any and all state laws insofar as they . . . relate to any employee benefit plan.'"<sup>175</sup> Despite Congress's intent that the "relates to" clause be applied broadly, some courts

have not been so deferential.<sup>176</sup>

One commentator has suggested that judicial review "through a flexible and adaptive judicial doctrine of preemption" might have been a better method to resolve conflicts between state and federal interests.<sup>177</sup> In *Standard Oil Company of California v. Aghsalud*,<sup>178</sup> in which Standard Oil first challenged the PPHCA alleging it had been preempted by ERISA, Judge Renfrew of the United States District Court, Northern District of California, held that ERISA did in fact preempt the PPHCA. However, he very importantly noted that:

[b]y enacting ERISA, Congress created a moratorium of indefinite length of the passage of health insurance laws. Congress could rationally have decided to take a different course. It troubles the Court, as it troubles defendants, that Congress preempted state health insurance laws apparently without specific discussion of the need for such a step. The workers whom ERISA was primarily intended to protect may be better off with state health insurance laws than without them, and the efforts of states like Hawaii to ensure that their citizens have low-cost comprehensive health insurance may be significantly impaired by ERISA's preemption of health insurance laws.<sup>179</sup>

Judge Renfrew urged Congress to consider the advice of Justice Brandeis:

Federal legislators should heed the admonition that Justice Brandeis addressed to the federal courts: "To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."<sup>180</sup>

One commentator has opined that the savings clause is unambiguous and should be accepted for its plain meaning. "ERISA expressly states that it does not preempt state laws that regulate insurance: '[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance. . . .'"<sup>181</sup>

In 2003, the U.S. Supreme Court acknowledged that healthcare and insurance regulation have historically been state domain and "that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."<sup>182</sup> ERISA's preemption clause was intended to protect

164. Joseph M. Silvestri, *Employer Plan Design Requirements: Federal and State Regulation of Employer-Provided Health Benefits*, 393 PLI/Comm 315, 334 (1986)(emphasis added).

165. Groves, *supra* note 160, at 620-24.

166. 793 F.Supp. 524 (D.N.J. 1992).

167. *Id.* at 526.

168. *United Wire, Metal and Machine Health and Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179, 1189 (3rd Cir. 1993).

169. 510 U.S. 944 (1993)(*Reh'g Den.*).

170. Groves, *supra* note 160, at 620-21.

171. *Id.*

172. *Id.* at 621 (quoting Richard A. Hopp et al., *Report to Washington Health Care Commission on Preemption of State Laws Regulating Health Benefits* 9 (June 30, 1992)(unpublished report on file with the Columbia Journal of Law and Social Problems)).

173. Groves, *supra* note 160, at 621.

174. Stabile, *supra* note 44, at 37.

175. 29 U.S.C. §1144 (1998).

176. Groves, *supra* note 160, at 618-19. See, e.g., text and *supra* notes 162-65 (discussing *United Wire, Metal and Machine Health and Welfare Fund v. Morristown Memorial Hospital*).

177. Irish, *supra* note 59, at 153.

178. 442 F.Supp. 695 (1977).

179. *Standard Oil Co. of California v. Aghsalud*, 442 F.Supp. 695, 711 (9th Cir. 1977) (Renfrew, J.).

180. *Id.* (citations omitted).

181. Donald T. Bogan, *Saving State Law Bad-Faith Claims From Preemption*, 39 TRIAL 52, 56 (Apr. 2003)(citing 29 U.S.C. §1144 (b)(2)(A)).

182. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).

pension plans and retirement benefits, not to preempt state sovereignty in health and insurance, and to apply a broader interpretation to the preemption clause would require clear Congressional intent. The Court today appears to be contracting ERISA's broad preemption clause.

Further guidance in this area of ERISA preemption of state laws is found in *Kentucky Assn. Of Health Plans, Inc. v. Miller*. In this 2003 case, the Court held

Today we make a clean break from the McCarran-Ferguson factors and hold that for a state law to be deemed a 'law' . . . which regulates insurance under §1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured.<sup>183</sup>

Perhaps the Court's new direction relating to the savings clause will provide an alternative to an otherwise inflexible PPHCA.

### C. Federal Intervention

One federal approach would be a Department of Justice ("DOJ") investigation.<sup>184</sup> The advantages of a DOJ analysis include expertise in antitrust evaluations, the resources needed to perform econometric studies, and the general belief that an outside agency will look objectively at a situation in which the State itself may have been negligent by not providing adequate oversight and supervision of the PPHCC.<sup>185</sup> Several procedures are available for enforcing antitrust law: criminal punishment,<sup>186</sup> equitable relief including proceedings in equity,<sup>187</sup> private suits in equity,<sup>188</sup> consent decrees,<sup>189</sup> and also private actions.<sup>190</sup>

However, a Congressional amendment which would allow Hawaii to change its PPHCA would most directly remove the restrictions

under which Hawaii's current health care system must operate. The 1983 exemption that holds the PPHCA to its 1974 language<sup>191</sup> prevents any contemporary response to meeting increasing health care costs and changing demographics. Many feel that ERISA in general "has had a disastrous effect on state efforts to improve access to health care."<sup>192</sup> They hold little hope that any state's attempt to obtain corrective action from Congress can be successful, especially in view of Hawaii's protracted attempt from 1974 to 1983 to obtain its exemption.<sup>193</sup> Congress's original intent with ERISA was to establish a uniform nation-wide standard for employee rights and employer responsibilities in order to stabilize pension plans and protect retirees.<sup>194</sup> Because of this original aim toward national uniformity, ERISA stifles state innovation and modern response to current health care needs.

Consideration should also be given to actually repealing the PPHCA. This is probably the best way to open the doors to competition. Although proponents will argue that Hawaii employees will lose health care benefits, this author believes it more likely that employers would continue to provide insurance to employees just as they did from 1974-1983,<sup>195</sup> while the PPHCA was actually preempted by ERISA. Even in the absence of a mandate, it is highly likely that providing medical benefits will remain an important way in which small business employers can compete for more qualified employees.<sup>196</sup>

### V. Conclusion

In 1974, two laudable events occurred: Hawaii passed the PPHCA, designed to ensure that more of its citizens have access to reasonable health care coverage at a reasonable price;<sup>197</sup> and Congress passed ERISA, designed to assure American citizens that pension and other employee benefit plans would be well-managed and kept solvent.<sup>198</sup> Congress attached a very broad preemption clause to

183. 123 S.Ct. 1471 (Apr. 2, 2003)(internal citations omitted).

184. Cho, *supra* note 28.

185. See *supra* notes 132-133 and accompanying text for a discussion of state action immunity.

186. Areeda, *supra* note 9, at 54. "Violations of §1 and §2 of the Sherman Act, however, are criminal and are punishable by imprisonment up to three years and fines up to \$350,000 for an individual and up to \$10 million for a corporation." *Id.*

187. *Id.* at 60.

Sherman Act §4 and Clayton Act §15 confer jurisdiction on the federal courts "to prevent and restrain violations of this act" and direct the government "to institute proceedings in equity to prevent and restrain [antitrust] violations." The Supreme Court has understood the power under this statute to embrace "such orders and decrees as are necessary or appropriate" to enforce the statute.

*Id.* (citing *Northern Sec. Co. v. United States*, 193 U.S. 197, 344 (1904)).

188. Areeda, *supra* note 9, at 62.

Since 1914, Clayton Act §16 has permitted private persons to obtain injunctive relief against actual or threatened antitrust injuries. To have standing, the private litigant must demonstrate a significant threat of injury to itself. But where the anticompetitive effect or potential of the defendant's behavior would warrant an injunction in a government suit, the court may well proscribe the defendant's activity without close scrutiny of the harm claimed by the private plaintiff.

*Id.*

189. *Id.* at 63.

190. *Id.* at 73.

The treble damage remedy gives private persons a powerful financial incentive to enforce the antitrust laws. Under both the Sherman Act and the Clayton Act, any private person "injured in his business or property by reason of anything forbidden in the antitrust laws . . . shall recover threefold the damages by him sustained, and the cost of suit, including a reasonable attorney's fee."

*Id.*

191. See *supra* notes 82-83 and accompanying text.

192. *Id.* at 405.

193. Groves, *supra* note 160, at 635.

194. Holloway, *supra* note 41, at 416.

195. Law, *supra* note 73.

196. Telephone discussion with Senator Sam Slom, President of Small Business Hawaii, an economist, and Senator, Hawaii State Legislature (October 2002).

197. See *supra* note 13 (citing HAW. REV. STAT. §393-2 (1993)).

198. See *supra* notes 39-41, and accompanying text.

ERISA in order to insure that all Americans would be covered and that ERISA plans would be portable.<sup>199</sup> This clause, however, had the unfortunate effect of preempting the Hawaii PPHCA.<sup>200</sup>

Later, Congress granted Hawaii a unique exemption from ERISA preemption and provided an opportunity for Hawaii's statewide experiment in employer mandated health care coverage.<sup>201</sup> However, Congress's grant of this ERISA exemption also tied Hawaii to the law (PPHCA) as it was enacted in 1974.<sup>202</sup> Now, almost three decades later, Hawaii's PPHCA has become outmoded and untenable. Further, the PPHCA likely failed its original purpose of increasing health care access. The number of insureds in 1969, 88.1%, is not appreciably different from that in 1999, three decades later, at 88.9%.<sup>203</sup> Although Hawaii's marketplace and demographics have changed dramatically<sup>204</sup>, Hawaii remains tied to the 1974 PPHCA language and therefore is unable to address modern demands.

The constraints of Hawaii's express exemption deny Hawaii any flexibility in meeting the new demands of a changed market.<sup>205</sup> These demands are exemplified by the conflict between balancing increased patient expectations and higher longevity with decreased resources and higher costs of providing that care. Additionally, the language of the Act itself calls for new plans to meet a standard of benefits set by the largest plans in the state. This type of regulation has set an artificially achieved benchmark and is not a benchmark achieved as a result of a freely competitive market.

Further, the PPHCA was implemented in such a way that it raised questions of conflict of interest and monopoly maintenance. The DLIR Director's responsibility is to administer the Act<sup>206</sup> after receiving recommendations and advice from the Council.<sup>207</sup> The Director determines whether any applicant plan meets mandated

requirements.<sup>208</sup> However, in the past, health plans applying to do business in the state found a formidable hurdle in both the application process and in meeting the benchmark as set by the PPHCA and as implemented by the Council.<sup>209</sup> Formerly, applicant plans were at a distinct disadvantage, having to share proprietary information with marketplace competitors<sup>210</sup> who were members of the committee.<sup>211</sup> This created a glaring conflict of interest, at worst, illegal monopoly maintenance, and at best, an appearance of impropriety.

As HMSA and Kaiser have recently resigned their memberships on the Council, the Governor's newly appointed DLIR Director has a fresh opportunity to review the composition and functions of the Council and to provide safeguards to protect proprietary information. The State must insure active supervision of the Council's activities in order to encourage the entry of new competitors to the Hawaii market.

The State may also consider implementing initiatives, on a local level, of 1) laws of general applicability, and 2) laws that relate to insurance regulation. Both of these approaches may give Hawaii options to deal with rising health care costs, and would not be at odds with ERISA. Indeed, the language that authorizes these approaches is found within ERISA itself.<sup>212</sup>

Additionally, the State may ask its Congressional delegation to pursue a broader ERISA exemption, one that will allow Hawaii to change its PPHCA, encouraging competition and promoting innovation in its health care delivery system. Undoubtedly, it will take courage, tenacity, and resources to honestly evaluate the effects of the PPHCA, to pursue the modifications necessary to make it relevant for today's world, and, alternatively, to work for its repeal if other solutions prove untenable.

199. See *supra* notes 42, 46-48, and accompanying text.

200. See *supra* notes 44-45, and accompanying text.

201. See *supra* notes 6-7, 81, and accompanying text.

202. See *supra* notes 82-83, and accompanying text.

203. See *supra* notes 15-16, and accompanying text.

204. See *supra* note 156, and accompanying text.

205. See *supra* notes 151-155, and accompanying text.

206. See *supra* notes 23-24, and accompanying text.

207. See *supra* note 25, and accompanying text.

208. See *supra* notes 33-38, and accompanying text.

209. See *supra* notes 104-105, 127-130, and accompanying text.

210. See *supra* notes 104-108, and accompanying text.

211. See *supra* notes 11-12, 105, and accompanying text.

212. See *supra* notes 163-173, and accompanying text.